Dialectics Associated with Implementation of Dialectical Behaviour Therapy in Canadian Federal Correctional Institutions for Women

**By Gordana Eljdupovic, Dominique
Lapierre and Joanie Reimer,
Correctional Service of Canada**

In past decades, there has been growing evidence that Dialectical Behaviour Therapy [DBT] is an effective treatment for behaviour and emotional dyscontrol (Linehan et al., 2006; Perroud et al., 2010; Woodberry & Popenoe, 2008; Shelton et al., 2009). While initially developed for individuals with Borderline Personality Disorder [BPD] with histories of repeated suicide attempts and self-harm, it rapidly became an effective treatment for a vast range of disorders including depression, post-traumatic stress disorder, eating disorders

While initially developed for individuals with BPD, it rapidly became an effective treatment for a vast range of disorders

and substance abuse (Koerner & Linehan, 2000; Steil et al., 2011; Axelrod et al., 2011; Kroger et al., 2010). Moreover, DBT acknowledges high risk of staff burnout when working with such clientele, and as a result, an integral treatment component, namely Consultation Team meetings, was developed to target issues specifically associated with burnout.

Given the high prevalence of complex cases of mental disorders among incarcerated populations (James & Glaze, 2006; Cunliffe et al., 2012; Australian Institute of Health and Welfare, 2010; CSC, 2009; Nee & Farman, 2007) as well as high levels of staff burnout in forensic and prison settings (McCann & Ball, 2000; Roy et al., 2010; Finney et al., 2013), it is not surprising to witness growing interest for DBT implementation in these settings. Several authors have reported positive results in such contexts while acknowledging the need for further and more robust studies (Thompson Wahl, 2010; Shelton et al., 2009; Nee & Farman, 2005; Nee & Farman, 2007; Gee & Reed, 2013; Robertson et al., 2011). However, the literature on implementing DBT in such settings is scarce, including the specific challenges which may not be found in an outpatient clinic or mental health agency (Shelton et al., 2009, p. 789; McCann & Ball, 2000; Van den Bosch et al., 2012).

This paper will describe the CSC DBT context and offer an analysis of the main challenges of DBT implementation in Canadian federal correctional settings for women. The

ABSTRACT

This article describes implementation of Dialectical Behaviour Therapy [DBT] in Correctional Service of Canada [CSC]'s institutions for women. A brief overview of the targeted population, outcomes of research studies pertaining to the effectiveness of DBT within the CSC context as well as a description of its current model will be presented. Prominent dialectics and challenges encountered in implementing DBT within this correctional setting will be discussed.

SAMMENDRAG

Artikkelen beskriver implementeringen av Dialektisk atferdsterapi (DBT) i kvinnefengsler drevet av kriminalomsorgen i Canada (Correctional Services of Canada). Artikkelen gir en kort oversikt over populasjonen og forskningen på effekten av DBT for personer i kriminalomsorgen, samt en beskrivelse av modellen. Dialektiske dilemmaer og utfordringer man støter på ved implementering av DBT i kriminalomsorgens institusjoner diskuteres.

analysis is anchored in the fundamental 'acceptance versus change' dialectic, which informs our strategies as we navigate this complex landscape and identify other dialectical polarities or challenges. As described by Robins et al. (2004), DBT holds synthesis of many dialectical polarities, acceptance and change being the most fundamental one since "the inability to accept one's behaviour prohibits any ability to change" (p.31). Essentially, "dialectics should not be viewed as some dynamic balance or homeostatic environment.... Rather, dialectics involves the complex interplay of opposing forces" (p.34).

DBT Implementation in CSC and Targeted Population

In 2001, CSC started implementing DBT in its institutions for women across Canada. Within a few years, its implementation was completed in all five regional institutions. As has already been described by Berzins and Trestman (2004), the treatment model consisted of weekly skills training sessions, weekly individual therapy, in-milieu ongoing support (day-to-day scheduled and as needed coaching to facilitate skills acquisition) and staff meetings, as well

as the provision of adapted DBT training to all staff. The overall philosophy and characteristics of the implemented DBT model were almost identical at all institutions.

Within a few years, its implementation was completed in all five regional institutions

Federally sentenced women in Canada have been charged with violent crimes, offences against property and/or other violations of the Criminal Code. Sentences range from two years to life. CSC data (2009) reveals that

29% of women in a federal institution had a mental health problem at admission. In addition, 43% engaged in self-injurious behaviour, and 75% attempted suicide. Women who were specifically targeted for DBT were those who exhibited suicidal/self-injurious behaviors, adjustment problems related to mental health issues, difficulties with life skills/daily activities, and/or other emotional or behavioral dysregulation.

In spite of the differences between forensic and correctional settings, Van den Bosch et al. (2012)'s statement that "the focus of forensic psychiatry is not on effective treatment of BPD problems, but on the prevention of criminal recidivism" (p. 312) also applies to CSC's overall approach. However, CSC also recognizes that in some cases, targeting factors exclusively related to criminal recidivism is ineffective or impossible for at least two reasons. Firstly, in some cases, criminogenic factors are precisely the main presenting issues of individuals diagnosed with BPD and targeted by DBT (i.e. impulsivity). Secondly, for an inmate to effectively engage in correctional interventions, sufficient emotional and behavioural regulation needs to occur (for instance, repeated head banging precludes one from taking part in any type of correctional programming). Therefore, engaging in DBT may be necessary prior to an inmate's participation in correctional programs.

Summary of CSC Research Studies on Implemented DBT Model

Following the implementation of DBT in CSC's institutions for women, a preliminary evaluation of DBT was conducted utilizing qualitative research methods (Sly & Taylor, 2003). Forty-two staff and 23 offenders from four institutions for women participated in semi-structured interviews, of which 20 staff also filled out a survey. This study intended to evaluate the understanding and attainment of DBT goals in offenders as well as in staff, the effectiveness of training, measurement tools, documentation associated with DBT, and general effectiveness of the treatment approach (Sly & Taylor, 2003).

Preliminary results found that both staff and participants perceived the goal of DBT as helping participants decrease ineffective behaviours by teaching them more effective ways of managing their problems. Results indicated that both staff and participants set personal goals in DBT, with 59% of staff and 56% of participants reporting progress towards their identified personal goals. According to preliminary findings, a strong proportion of the staff and participants described finding the treatment tools and DBT language difficult to understand. Nevertheless, overall, the majority of staff interviewed found DBT to be a positive and worthwhile intervention, mostly providing feedback focused on improving the current approach of DBT as it was in its early stages of implementation. Sly and Taylor (2003) concluded that all in all, "the preliminary evaluation of DBT provides support for the treatment approach and its value for the client population it serves" (p. 31).

Sly and Taylor (2003) identified three main limitations of this preliminary evaluation. One limitation recognized that due to the study's nature and population, a true random sample of the study participants was not possible. The use of a semi-structured interview was the second limitation identified, since not all staff and participants answered every interview question and as such, there was lack of information in relation to some questions. A third limitation highlighted the possibility of overlap in staff that participated in an interview and completed an anonymous survey.

In conjunction with the preliminary qualitative evaluation, a follow-up evaluation utilizing quantitative methods was conducted in order to explore direct impacts of DBT intervention on participants (Blanchette et al., 2011). More specifically, this study assessed pre-post changes in "women's psychological symptoms and well-being, their ways of coping, their institutional behaviour, and their post-release outcome" (p. 24).

The quantitative evaluation procedure included a file review of information related to participants' behaviour while in the institution as well as following a release into the community. File information was reviewed at multiple stages during the data collection period. In addition, the evaluation procedure included the administration of a comprehensive assessment battery, intended to assess the impact of DBT intervention on domains such as institutional functioning, symptomatology and coping strategies.

Ninety-four participants from four different institutions for women contributed data during the research period; however, as a number of these participants did not complete an assessment battery at some time point, the data from 59 participants was included in the quantitative analyses.

COURTESY OF THE CORRECTIONAL SERVICE OF CANADA

Therefore, participants of this study were likely not representative for all offenders who fulfilled inclusion criteria. Data from the administered assessment battery was collected between 2001 and 2004. The review of file information proceeded until 2009, allowing time for participants to be released into the community and information on post-release outcomes to be reviewed and included for analyses in this evaluation (Blanchette et al., 2011).

Quantitative findings in this study indicated that DBT participants showed moderate to high improvements on a variety of measures, including increased coping skills, increased institutional functioning, lowered rates of self-injury, and decreased psychological symptoms (Blanchette et al., 2011). Blanchette et al. (2011) concluded that overall, “the adaptation of DBT to the correctional environment seems to have resulted in a very strong program to meet the unique needs of women with mental health and emotional or behavioural dysregulation needs” (p. 28).

Although these evaluations suggested that the CSC DBT model appeared to be an effective intervention, a number of challenges emerged over time. Sustaining the model became difficult in view of high staff turnover, a growing incarcerated population, the need for extensive training across all institutions, and associated financial constraints. Therefore, in 2011, CSC sought assistance from external DBT experts (Behavioural Tech and BPD Clinic, Centre for Addictions and Mental Health [CAMH]) to provide recommendations pertaining to model sustainability and effectiveness. As a result, building on existing strengths, amendments to the CSC DBT treatment and training models were implemented.

Description of the Current CSC DBT Model

The current CSC DBT model consists of the following four main components. First, clinicians conduct weekly DBT individual therapy sessions in order to enhance and sustain motivation to practice and utilize skills, in order to reduce life threatening behaviours as well as those interfering with therapy or quality of life. This includes conducting a Behavioural Chain Analysis of the Key Crime with the goal of outlining deficit areas associated with committing the crime and relating them to treatment goals and skills training.

Second, skills training groups occur 1 to 3 times a week in order to target skills deficits and strengthen clients' skills acquisition. Given the recruitment difficulties of licensed clinicians who are often unavailable for co-facilitation, these sessions are mainly provided by Behavioural Counsellors [BCs], who are unlicensed mental health workers.

Third, weekly DBT consultation team meetings are held in order to target staff burnout and enhance staff capabilities and motivation; they mainly involve clinicians and BCs, with other staff joining upon availability.

Fourth, ongoing in-milieu coaching is provided, mostly by BCs, to encourage individuals to utilize their skills. However, other non-clinical staff also receives training to provide coaching as needed.

The CSC DBT training model varies in intensity depending on the staff's role in treatment. A greater level of involvement in treatment is paired with a greater involvement in training. As shown in Table 1, staff who have daily ‘on the fly’ interactions with offenders receive 2 days of training whereas clinicians who conduct and oversee treatment receive a total of 12 days of training.

Table 1 Training Model

	Self-study	Intro& Coaching Module	Consult. Team Module	Skills Training Module	Individual Treatment Module	Total Training Days
Clinicians	5	3	1	2	2	12
BCs	3	2	1	2	0	8
Training delivery type	Self-study	Regional Delivery	National Delivery			
Frequency	One time training					
Time frames	2 mths*	8 mths*	Within 6 months of Intro & Coaching Module Training			

*Number of months allowed after hiring for training to take place
Table excludes Refresher Training (described later)

Within this training model, special attention has been given to refresher training, which focuses on providing institutional DBT teams ongoing consultations and periodical review of main DBT concepts previously covered in trainings. There are two main reasons for designing such 'fluid,' on-going refreshers. First, consistent with principles of learning, skills and content acquired during training are difficult to retain without practice and ongoing feedback. Secondly, past CSC experience showed that, such vast implementation of the DBT model in all federal regional facilities for women across Canada required ongoing efforts, commitment and communication in order to obtain 'buy-in' from both clinical and non-clinical staff, to change the existing 'epistemological paradigm,' that is, entrenched traditional ways in which behaviours are conceptualized and therefore addressed, to instill hope, and to reinforce a non-judgmental stance and compassionate understanding of often highly aggressive individuals who have committed serious crimes.

As presented in Table 2, various DBT training refreshers are therefore provided. For instance, every six months, all staff receive a one-hour Webinar which reviews core DBT concepts and every two years they receive one half-day in-class DBT refresher which offers an opportunity for 'hands on' practice in relation to current challenges in the institution. There are also three types of ongoing telephone consultations that are offered. These consultations are provided by DBT experts from the BPD Clinic at CAMH. These consultations target aspects of the DBT model that were identified as the most challenging to implement; more specifically, how to assist staff in adhering to the DBT model and its assumptions. These telephone consultations are provided to: 1) DBT Consultation teams at each institution separately; 2) all DBT clinicians who conduct individual sessions across all five sites (complex case clinical rounds), and 3) entire DBT teams from all sites (cross-site conferences).

Table 2 Refresher Training Model

Training Type	Clinicians	BCs	Other staff
In-Class Training	Yes	Yes	Yes
Webinars Training	Yes	Yes	Yes
Consult. Team Meetings*	Yes	Yes	Correctional managers of DBT units
Complex Case Clinical Rounds*	Yes	Yes	No
Cross-Sites Conferences*	Yes	No	No

*Phone consultations

There are significant benefits to these refresher activities. For instance, implementing consultation team meetings into a prison setting that is hierarchical in nature with clear, rigid reporting structures poses specific challenges. The rigid and disciplinarian structure, with safety and security of the institution being a priority, can be highly invalidating for offenders (McCann et al., 2007). The same may apply to staff and can hinder their willingness to voice their sense of ineffectiveness in working with an inmate (or colleague) and ask their team for help. In addition, the very structure and process of running DBT Consultation Team may be quite foreign to staff. In order to assist institutional DBT teams to effectively run Consultation Team meetings, each month an external DBT consultant joins the institution's DBT Consultation Team meeting via phone and provides guidance with following the meeting structure and utilizing DBT strategies. The same process applies to the other two types of telephone consultations.

As voiced by many staff, the most important benefits of these consultations are DBT consultants' modeling the application of DBT principles throughout consultation regardless of the presenting problem. This inevitably promotes and reinforces dialectical thinking, compassion and application of DBT strategies.

Ongoing Dialectics in the Implementation of the CSC DBT Model

Implementing an elaborate and complex treatment approach within a complex organization such as CSC cannot be expected to occur without complexities. A number of specific challenges of DBT implementation in prison and forensic settings have already been documented (McCann & Ball, 2000; Shelton et al. 2009; Van den Bosch et al., 2012; Nee & Farman, 2005) and we have observed similar challenges within our context. In response to reviews of the initial CSC DBT model, some solutions were successfully applied and the model has evolved with noted improvements. However, it is inevitable that some of the complexities remain or that new situations have appeared along the way. We have found the 'acceptance versus change' dialectic to be a helpful guide in approaching and managing the challenges associated with DBT implementation.

The following section presents the main dialectical tensions and/or challenges being experienced (on the acceptance side of the dialectic) as well as an exploration of the strategies that are being applied to address them (on the change side of the dialectic). Consistent with a problem-solving approach, a clear formulation of the difficulties is necessary in order to increase effectiveness. This includes focusing on determinants that may get in the way of effectiveness (i.e. lack of skill, knowledge, environmental contingencies, emotions, problematic thinking, etc.), a step which guides the choice of change strategies.

One specific dialectic tension between the need for security and the treatment arises within the correctional environment, as also outlined by McCann and Ball (2000). While these two major forces are usually not opposites, it is sometimes quite a challenge to balance them effectively. It may occur, for instance, when an offender deals ineffectively with her distress by engaging in self-harm. In such instances, security protocols imply a significantly higher level of care and surveillance which, while understandable,

may inadvertently reinforce the exact behaviour that the treatment aims to reduce. Change strategies related to this challenge include the provision of ongoing DBT training to staff (mainly reminders of the principles of learning), and on-going consultations. At the organizational level, change strategies include provision of DBT orientation sessions for decision makers in order to promote education, buy-in and support for the DBT approach, integration of some DBT principles into institutional guidelines and rules, and highlighting the decrease of costs related with investing into the DBT approach versus the traditional correctional approach.

Another challenge or tension, this time noted within the treatment team, is that it is only once they are hired that most employees learn that they are expected to adopt the DBT framework. While this may be a perfect fit for some, it can create significant polarization as others may subscribe to different or opposing theoretical frameworks. Therefore, staff on a given team may have varied levels of adherence (if at all) to the DBT philosophy and intervention. This can lead to lack of commitment or therapy-interfering behaviours, which significantly decreases the team's effectiveness and motivation. Change strategies applied to this challenge include using DBT strategies such as highlighting polarization throughout all consultations, validating staff's opposition or frustration, highlighting freedom to choose, radical acceptance, obtaining buy-in by presenting pros and cons of utilizing treatment which is effective in increasing offenders' emotion and behavioural regulation, which consequently decreases institutional incidents (and staff's stress).

A third challenge associated with implementation of DBT within the prison setting is that regardless of initial level of interest, the majority of staff, clinical and correctional, exhibit exceptionally high levels of enthusiasm and motivation for the model following DBT training. However, it appears difficult to sustain such levels of commitment thereafter; their adherence to DBT principles and structure

in daily practices rapidly subsides. Problem-solving regarding this challenge begins by identifying factors that get in the way of sustaining motivation. For example, fast pace and often unpredictable prison environment render staff feeling 'pulled in many directions,' which may further lead them to skip Consultation team meetings in order to attend

to other duties. Therefore, formal scheduling of DBT consultations with supervisors' approval and support for staff to attend was put in place. Secondly, as previously described, consultations are conducted by external DBT experts who consistently model a dialectical approach to dealing with situations, which adds a new dimension to the traditional correctional philosophy of emphasizing

We have found the 'acceptance versus change' dialectic to be a helpful guide in approaching and managing the challenges associated with DBT implementation

the change of behaviours, rather than acceptance or compassion.

The fourth challenge or tension pertains to the fact that offenders are a captive audience (incarceration being involuntary) while important outcomes during their incarceration are linked to their participation in therapy (which is voluntary). For instance, participation in DBT may lead to decrease in security level or to the person obtaining conditional release. Therefore, while offenders may be attending treatment, they may not be committed to it (which significantly exceeds the expected fluctuation in clients' treatment commitment). In that regard, it is indeed different to work with clients in outpatient clinics, who sometimes have to wait for over a year for admission to DBT, which suggests significant commitment as opposed to attending treatment because it will "look good on paper"; however, it should be noted that there are instances in the community where cli-

COURTESY OF THE CORRECTIONAL SERVICE OF CANADA

COURTESY OF THE CORRECTIONAL SERVICE OF CANADA

ents also attend treatment because it 'looks good on paper' for various court proceedings. Facing this challenge on a regular basis discourages staff. Change strategies applied to this issue target both staff and offenders. National DBT consultations focus on instilling hope and validating these difficulties. They invite collaborative problem solving regarding strategies of 'selling DBT' to offenders, staff's opportunity to apply commitment strategies and increase the likelihood of offenders' stronger commitment to treatment.

The fifth challenge is that our clients are usually complex, 'hard to treat' cases with a number of issues in many areas of their lives. We witness a high demand for repeated interventions, with minimally apparent results. This can lead

to a decrease in team motivation and an increase in burnout. Problem-solving strategies that are applied to this challenge include placing emphasis upon supporting and reinforcing DBT teams to adhere to Consultation team structure and agreements, ongoing validation of the inherent difficulty in working with the offender population, highlighting the importance of shaping and

reinforcing 'small' steps or any traces of effective behaviour clients demonstrate, and inviting willingness to radically accept that everyone is doing the best they can. More specifically, most federally sentenced incarcerates have nowhere else to go, as they have repeatedly rotated through various mental health systems and other levels of 'care'. As described by Berzin and Trestman (2004), "the nation's correctional system has essentially become its default mental health system" (p. 93). As such, both offenders as well as staff working in prisons witness the same individuals coming in and out of the system, often without alternative options.

More than ten years of CSC experience with implementing DBT certainly confirms the value of integrating this treatment within a correctional system

The sixth and final challenge addressed in this article pertains to the dialectical polarity of resource allocation. The dilemma here is whether to allocate significant resources in order to achieve minimal changes in complex, 'hard to treat' women, as described above and which includes higher risk of staff burnout, or to allocate the same or lesser amount of resource in order to achieve greater changes in higher-functioning inmates and by doing so, provide service to a greater number of offenders. More specifically, it has been noted that DBT is often sought by offenders with higher levels of functioning who can nevertheless benefit from learning more effective interpersonal and emotion regulation skills. Working with these offenders is significantly more rewarding for staff, because they show visible progress faster. However, limited resources force prioritizing offenders and providing services to those with higher needs and lower levels of functioning. This in turn, as discussed previously, leads to greater staff burnout and decrease of motivation. In order to meet these equally valid competing priorities, dialectical synthesis seems to be a possible solution. For example, we are currently examining an option to offer a DBT-based psycho-educational model, which would provide an opportunity for inmates to learn DBT skills while not receiving the whole spectrum of services (therefore requiring less staff resources). It may be an effective synthesis of organizational, staff and offender needs, as it will allow clients to be equipped with needed 'tools', increase staff motivation by facilitating opportunity to see more immediate positive effects of their work, 'advertise' DBT by making it accessible to greater number of offenders in the institution. At the same time, required resources will still be available to offer comprehensive and more taxing services to clients with higher needs.

Conclusion

More than ten years of CSC experience with implementing DBT certainly confirms the value of integrating this treatment within a correctional system, since its targets, such

as client emotional/behavioural dysregulation and staff burnout, are established realities in such settings. The challenges associated with model implementation are numerous and complex; they require on-going staff coaching and explicit management and supervisors' support. Addressing these challenges is a time-consuming process; it requires allocation of sufficient resources, commitment and dedication on the part of administrators as well as service providers. Although it may seem overwhelming at times, we are witnessing the evolution of our DBT model since its initial implementation, which will hopefully gradually lead us to a stronger fidelity of the model.

REFERENCES

- Australian Institute of Health and Welfare. (2012). The mental health of prison entrants in Australia 2010. Bulletin no. 104. Cat. no. AUS 158. Canberra: AIHW.
- Axelrod, S. R., Perepletchikova, F., Holtzman, K., & Sinha, R. (2011). Emotion regulation and substance use frequency in women with substance dependence and borderline personality disorder receiving dialectical behavior therapy. *American Journal of Drug and Alcohol Abuse*, 37(1), 37-42.
- Berzins, L. G., & Trestman, R. L. (2004). Development and implementation of dialectical behavioural therapy in forensic Settings. *International Journal of Forensic Mental Health*, 3(1), 93-103.
- Blanchette, K., Flight, J., Verbrugge, P., Gobeil, R., & Taylor, K. (2011). Dialectical Behaviour Therapy within a women's structured living environment. Research Report R-241. Ottawa, ON: Correctional Service of Canada.
- Correctional Service of Canada. (2009). The changing offender population. Highlights, 2009. Ottawa, ON: Author.
- Cuniffe, C., Van de Kerckhove, R., Williams, K., & Hopkins, K. (2012). Estimating the prevalence of disability amongst prisoners: results from the Surveying Prisoner Crime Reduction (SPCR) survey. London: Ministry of Justice. Retrieved from <https://www.gov.uk/government/publications/estimating-the-prevalence-of-disability-amongst-prisoners>
- Finney, C., Stergiopoulos, E., Hensel, J., Bonato, S., & Dewa, C. S. (2013). Organizational stressors associated with job stress and burnout in correctional officers: a systematic review. *BMC Public Health*, 13: 82. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3564928/>
- Gee, J., & Reed, S. (2013). The HoST programme: A pilot evaluation of modified dialectical behaviour therapy with female offenders diagnosed with borderline personality disorder. *European Journal of Psychotherapy and Counselling*, 15 (3), 233-252. Retrieved from <http://dx.doi.org/10.1080/13642537.2013.810659>
- James, D. J., & Glaze, L. E. (2006). Mental health problems of prison and jail inmates. U.S. Department of Justice. Office of Justice Programs.
- Koerner, K., & Linehan, M. M. (2000). Research on dialectical behavior therapy for patients with borderline personality disorder. *Psychiatric Clinics of North America*, 23(1), 151-67.
- Kroger, C., Schweiger, U., Sipos, V., Kliem, S., Arnold, R., Schunert, T., et al. (2010). Dialectical behaviour therapy and an added cognitive behavioural treatment module for eating disorders in women with borderline personality disorder and anorexia nervosa or bulimia nervosa who failed to respond to previous treatments. An open trial with a 15-month follow-up. *Journal of Behaviour Therapy and Experimental Psychiatry*, 41(4):381-8.
- Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63(7), 757-66.
- McCann, R. A., & Ball, E. M. (2000). DBT with an inpatient forensic population: The CMHIP forensic model. *Cognitive and Behaviour Practice*, 7, 447-456.
- McCann, R. A., Ivanoff, A., Schmidt, H., & Beach, B. (2007). Implementing dialectical behavior therapy with an inpatient forensic population in residential settings with adults and juveniles. In Dimeff, L., Linehan, M. M., & Koerner, K., *Dialectical Behavior Therapy in Clinical Practice: Applications Across Disorders and Settings* (pp. 112-144). New York: Guilford Press.
- Nee, C., & Farman, S. (2005). Female prisoners with borderline personality disorder: some promising treatment developments. *Criminal Behaviour and Mental Health*, 15, 2-16.
- Nee, C., & Farman, S. (2007). Dialectical behaviour therapy as a treatment for borderline personality disorder in prisons: Three illustrative case studies. *The Journal of Forensic Psychiatry & Psychology*, 18(2), 160-180.
- Perroud, N., Uher, R., Dieben, K., Nicastrò, R., & Huguelet, P. (2010). Predictors of response and drop-out during intensive dialectical behavior therapy. *Journal of Personality Disorders*, 24(5), 634-50.
- Robertson, P., Barnao, M., & Ward, T. (2011). Rehabilitation frameworks in forensic mental health. *Aggression and Violent Behavior*, 16, 472-484.
- Robins, C. R., Schmidt, H., & Linehan, M. M. (2004). Dialectical Behaviour Therapy. Synthesizing Radical Acceptance with Skillful Means. In Hayes, S. C., Folette, V. M., & Linehan, M. M. *Mindfulness and Acceptance, Expanding the Cognitive Behavioral Tradition* (pp.30-45). New York: Guilford Press.
- Roy, S., Novak, T., & Miksaj-Todorovic, L. (2010). Job burnout among prison staff in the United States and Croatia: A preliminary comparative study. *International Journal of Criminal Justice Sciences*, 5, 189-202.
- Shelton, D., Sampl, S., Kesten, K. L., Zhang, W., & Trestman, R. L. (2009). Treatment of impulsive aggression in correctional settings. *Behaviour Sciences and the Law*, 27, 787-800.
- Sly, A., & Taylor, K. (2003). A preliminary evaluation of dialectical behavior therapy within a women's structured living environment. Research Report R-145. Ottawa, ON: Correctional Service of Canada.
- Steil, R., Dyer, A., Priebe, K., Kleindienst, N., & Bohus, M. (2011). Dialectical behavior therapy for posttraumatic stress disorder related to childhood sexual abuse: a pilot study of an intensive residential treatment program. *Journal of Traumatic Stress*, 24(1), 102-6.
- Thompson Wahl, C. (2010). Evaluation of a dialectical behavior therapy skills group for female inmates who voluntarily seek treatment: a pilot study (Doctoral dissertation). Retrieved from UMI Dissertation Publishing (3479921).
- Van den Bosch, L. M. C., Hysaj, M., & Jacobs, P. (2012). DBT in an outpatient forensic setting. *International Journal of Law and Psychiatry*, 35, 311-316.
- Woodberry, K. A., & Popenoe, E. J. (2008). Implementing dialectical behavior therapy with adolescents and their families in a community outpatient clinic. *Cognitive and Behaviour Practice*, 15(3), 277-286. Retrieved from <http://dx.doi.org/10.1016/j.cbpra.2007.08.004>

Levert: 09.02.16, Revidert: 20.05.16, Godkjent: 20.05.16

DR. GORDANA ELJDUPOVIC is a licensed clinical and forensic psychologist who worked with Correctional Service Canada (CSC) in a federal institution for women for a number of years, and is currently the national manager and coordinator for the implementation and delivery of Dialectical Behaviour Therapy (DBT) for CSC. She is the co-editor of the book "Incarcerated mothers: Oppression and Resistance," which was published in 2013.

Since obtaining her PhD in 1996, **DR LAPIERE** has worked as a clinical and forensic psychologist for the Pinel Institute in Montreal and, since 2008, for Correctional Services of Canada. For the past 12 years, she has specialized in the assessment and treatment of women offenders. Since 2009, she is also manager of mental health services in her institution.

JOANIE REIMER is a registered social worker and has been working for Correctional Service Canada [CSC] since 2010, providing institutional mental health services to both male and female offenders. She graduated with her BA in Social Sciences in 2007 and then her BSW in 2009, beginning her career with the Mobile Crisis Service in Winnipeg, MB. She has recently completed her MSW and has been enjoying the opportunity to provide DBT therapeutic services to female offenders the past 2 years.